WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

00559

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred: Harford Memorial Hosp.
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Street
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Carrie A Anderson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry Edward Anderson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25 - 1873

8. AGE: Years	Months	Days	If less than one day
71	5	11	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jacob Bull
13. Birthplace: , Md.

MOTHER
14. Maiden name: Elizabeth Duff
15. Birthplace: , Md.

16. Informant: Harry Edward Anderson
Address: Street Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 5 45 (month) (day) (year)
Cemetery or crematory: Dublin Southern
Location: Harford Co. Md.

18. Funeral director: F. S. Bailey
Address: Darlington Md.

19. Jan. 5 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 5 1945, at 2.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 21 1944, to Jan 5 1945 and that I last saw h.e.r alive on Jan 5 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia	5 days
Due to Arteriosclerotic Heart Disease	
Due to Hypertensive Cardiovascular Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles N. Frigo M.D.
M. D. or other)
Address: Harford Memorial Hosp Havre de Grace, Md. Date signed 1-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59-5)

00560

CERTIFICATE OF DEATH

Reg. Diat. No. 184

1. PLACE OF DEATH:
County: Harford.
City or town: Darlington RD #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford.
City or town: Darlington RD-1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Absalom Belcher.

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	Married.

6.(b) Name of husband or wife: Amanda Belcher.
6.(c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr.): Jan 21. 1885.

8. AGE:

Years	Months	Days	If less than one day
60		10	hrs. min.

9. Birthplace: Keystone W. Va. (Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business

FATHER
12. Name: Henry Belcher
13. Birthplace: Wyoming Co. W. Va.

MOTHER
14. Maiden name: Polly Lusk.
15. Birthplace: Wyoming Co W Va

16. Informant: Amanda Belcher.
Address: Darlington Md.

17. Burial. Date thereof: Feb 2 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or ~~crematory~~: Dublin cem.
Location: Dublin Md

18. Funeral director: Hubert P. Harkins
Address: Delta, Pa.

19. Jan 31 1945 M. G. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 31 1945, at 6 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1944, to Jan 31 1945
and that I last saw him alive on Jan 15 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Due to: Metrazol	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. P. Snodgrass M. D. or other
Address: Darlington Md Date signed: 1/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 12 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

00561

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County Harford
City or town Aberdeen (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 yrs.
Hospital, Institution, or street address where death occurred: 119 Bel Air Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Harford
City or town Aberdeen (If outside city or town limits, write RURAL and give nearest town)
Street No. 119 Bel Air Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William J. Bonnett

3. (b) Social Security Number 717-07-5764

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Annie G. Bonnett
6.(c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) February 11, 1886

8. AGE:

Years	Months	Days	If less than one day
58	11		hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Telegraphic Operator
11. Industry or business

FATHER
12. Name Ernest C. Bonnett
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Johanna T. Brockman
15. Birthplace Baltimore, Md.

16. Informant Mrs. Anna G. Bonnett
Address 119 Bel Air Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 20-45 (month) (day) (year)
Cemetery or crematory Grove Cemetery
Location Aberdeen

18. Funeral director Henry Tarring & Sons
Address Aberdeen Md.

19. Jan. 19 1945 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1945 at 1.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 16 1945, to Jan. 16 1945, and that I last saw h... alive on Jan. 16 1945

Immediate cause of death	DURATION
Coronary thrombosis	
Due to Arteriosclerosis	
Due to angina pectoris	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thos. P. Thompson M. D. or other
Address Aberdeen Md Date signed Jan. 19 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 3 1945
BUREAU V.S.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-12)

00562

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:
County HARFORD
City or town HAVRE DE GRACE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 DAYS
Hospital, Institution, or street address where death occurred:
HARFORD MEMORIAL HOSPITAL
How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County HARFORD
City or town ABERDEEN - BOX 456
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JUDITH ANN BOWEN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 4 1945

8. AGE: Years	Months	Days	If less than one day
		3	hrs. min.

9. Birthplace HAVRE DE GRACE, HARFORD, Md
(Town, county, and state)

10. Usual occupation INFANT

11. Industry or business

FATHER
12. Name GEORGE ALEXANDER BOWEN
13. Birthplace HARFORD Co., Md.

MOTHER
14. Maiden name Ethel Malliman Topp
15. Birthplace BALTIMORE, Md.

16. Informant Mrs. George G. Bowen
Address Aberdeen Md

17. Burial Date thereof Jan. 9-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Paul Lutheran
Location Near Aberdeen Md

18. Funeral director Henry Fanning Jones
Address Aberdeen Md.

19. Jan. 8 1945 C. L. Lewis M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1945, at 12.50P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 4 1945 to Jan 7 1945 and that I last saw her alive on Jan 7 1945

Immediate cause of death	DURATION
Congenital cardiac hypertrophy	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Louis Urchel M.D.
M. D. or other
Address Havre de Grace Date signed Jan 7 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 5 1945
BUREAU V.S.

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

(CITIES CORPORATE LIMITS ONLY)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00563

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, Institution, or street address where death occurred:
606 Green St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 606 Green St
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Mary Reynolds Crawford

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm W. Crawford
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Apr. 15, 1859

8. AGE: Years: 85 | Months: 9 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Cecil Co. Md.
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business:

FATHER
12. Name: John J. McMaster
13. Birthplace: Md.

MOTHER
14. Maiden name: Susanna Schritze
15. Birthplace: Md.

16. Informant: Mrs. Harry D. Crawford
Address: 606 Green St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 24 1945 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace

16. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.

19. 1-24 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

45

20. DATE OF DEATH: Jan. 22 1945 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Jan. 1 1945 to Jan. 21 1945 and that I last saw h... alive on Jan. 21 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Chronic Diffuse Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. L. Lewis M.D. M. D. or other
Address: Havre de Grace, Md. Date signed: 1-24-45

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-e)

00564

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Monrsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Monrsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rodney Lee Dunnick

3.(b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 7, 1944
8. AGE: Years | Months: 7 | Days: 5 | If less than one day: ..... hrs. ..... min.
9. Birthplace: Forest Co Md (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None
FATHER 12. Name: Robert M. Dunnick
13. Birthplace: Forest Co Md
MOTHER 14. Maiden name: Alice Dunnick
15. Birthplace: Forest Co Md
16. Informant: Robert Dunnick
Address: White Hall Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 24 1945 (month) (day) (year)
Cemetery or crematory: Monrsville
Location: Monrsville Md
18. Funeral director: H Harvey Webb
Address: Forest Hill Md
19. Jan 24 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 22 1945, at 9:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Birth 19.. to Jan 22 1945
and that I last saw him alive on Jan 1 1945

Immediate cause of death	DURATION
Congenital Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Paul D. Shanton MD (M. D. or other)
Address: Shrewsbury Pa Date signed 1-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 6 1945
BUREAU V.S.

THIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

00565

Reg. Dist. No. 185

1. PLACE OF DEATH

County Harford

City or town Havre de Grace.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~1 hr~~ 15 hrs

Hospital, institution, or street address where death occurred: Harford Memorial Hospital.

How long in hospital or institution? 15 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Colora.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Daniel Leonard Gordon.

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1945 5:00 AM

8. AGE: Years | Months | Days | If less than one day: 17 hrs. 25 min.

9. Birthplace Colora Cecil Co., Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Richard Gordon

13. Birthplace Havre de Grace, Harford Co., Md.

MOTHER 14. Maiden name Violet Coulter

15. Birthplace W. Va.

16. Informant Mrs Richard Gordon

Address Colora, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25 1945 (month) (day) (year)

Cemetery or crematory West Nottingham Cem.

Location Colora Md.

18. Funeral director L. J. Tyson.

Address Rising Sun Md.

19. Jan. 24 1945 A. L. Lewis M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1945 at 10:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-23 1945 to 1-23 1945 and that I last saw h.. alive on 1-23 1945

Immediate cause of death	DURATION
Prematurity	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Charles W Frigon M.D. M. D. or other

Address Harford Memorial Hosp. Havre de Grace Md. Date signed 1-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1945
BUREAU V.S.

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

00566

Reg. Dist. No. 182

1. PLACE OF DEATH:
County Harford
City or town Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Forest Hill Rfd
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Agnes Virginia Grafton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Richard E. Grafton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 27 - 1865

8. AGE: Years	Months	Days	If less than one day
79	9	12	hrs. ..... min.

9. Birthplace Chestnut Hill Harford Co Md
(Town, county, and state)
10. Usual occupation Home wife
11. Industry or business
FATHER 12. Name Joseph E. Gorsett
13. Birthplace Harford Co Md
MOTHER 14. Maiden name Sarah A Mark
15. Birthplace Chestnut Hill Md
16. Informant Willard Grafton
Address Forest Hill Md
17. Burial Date thereof Jan 11 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Deer Creek Harford Co Md
Location Chestnut Hill
18. Funeral director Martin F Kent
Address Jarrettsville Md
19. 1/11 1945 Priscilla Fawwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 9 1945 at 4 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1944, to Jan 9 1945
and that I last saw h.r. alive on Jan 7 1945

Immediate cause of death	DURATION
Chr Myocardial Disease	1 Yr
Chr Interstitial Nephritis	6 Mos
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address Forest Hill Md Date signed 1/9/45

RECEIVED
FEB 8 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

00567

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County Harford

City or town Edgewood Arsenal, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days in hosp. 2 yrs. at E A

Hospital, Institution, or street address where death occurred: Station Hospital, Edgewood Arsenal, Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State New York County New York

City or town New York
(If outside city or town limits, write RURAL and give nearest town)

Street No. 326 E. 52nd St., New York, N. Y.
(If rural, give LOCATION)

2.(a) If veteran, name war World War II ✓

3.(a) FULL NAME HOBAN, Francis H. ASN 32198596

3.(b) Social Security Number - - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Jeanette L. Hoban

7. Birth date of deceased (mo., day, yr.) October 21, 1916 6.(c) If alive, give age 28 years

Oct. 20, 1916

8. AGE: Years	Months	Days	If less than one day
28	2	24	....hrs. ....min.

9. Birthplace New York, N. Y.
(Town, county, and state)

10. Usual occupation U S Army

11. Industry or business

FATHER 12. Name James Hoban

13. Birthplace unknown

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Army Service Record

Address Edgewood Arsenal, Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Jan 16 1945 (month) (day) (year)

Cemetery or crematory Coleman Funeral Home

Location 1267 1st Ave., New York City

18. Funeral director Howard K. McConnaughey

Address Abingdon Maryland

19. Jan 16 1945 (Date rec'd by registrar) Marie M. Mouldsdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 January 1945, 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 January 1945, to 14 January 1945

and that I last saw him alive on 14 January 1945

Immediate cause of death 1. Fracture, skull, frontal and basilar, right, simple, incomplete. — DURATION

2. Cerebral contusion, left — 2 days

Due to

Due to

Other conditions Fracture, mandible, right. Laceration about right eye & right lower lip. (Include pregnancy within 3 months of death)

Major findings of operations Suturing of lacerations Date of op. 12 Jan 1945

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12 Jan 1945

Where did injury occur? Edgewood, Harford, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Automobile accident Injured at work? auth. pass

23. SIGNATURE Arthur L. Lagrone Capt MC AUS M. D. or other

Address Station Hospital, Edgewood Arsenal, Md. Date signed 15 Jan 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1945
BUREAU V. S.

Evidence for change of age of deceased is shown on FILM No G92 MAR 10 1945

00568

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 113 So. Strawberry Alley
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 113 So Strawberry Alley
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Annie (Moore) Hopkins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Married

6.(b) Name of husband or wife David Hopkins
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) May 30, 1891

8. AGE: Years	Months	Days	If less than one day
53 54	7	5	hrs. min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation housewife
11. Industry or business

FATHER
12. Name Frank
13. Birthplace

MOTHER
14. Maiden name Cooke
15. Birthplace

16. Informant Mr. David Hopkins
Address 113 So. Strawberry Alley, Hdeg.

17. Burial (Burial, cremation, or removal: Which?) Date thereof Jan. 7 1945 (month) (day) (year)
Cemetery or crematory Laurel Hill
Location Harford Co. Md.
18. Funeral director W. Madison Mitchell
Address Havre de Grace Md.

19. 1-5- 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1945, at 4 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1945, to Jan 4 1945
and that I last saw her alive on Jan 4 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1-2-45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Oliver L Cowan M. D. or other
Address Havre de Grace Date signed 1-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1945
BUREAU V.S

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-1)

CERTIFICATE OF DEATH

00569

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred: 618 Bourton St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 618 Bourton St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Carrie Emma Iley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 30, 1884

8. AGE: Years: 60 | Months: 9 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: House Duties
11. Industry or business: Home

FATHER
12. Name: Jacob Christopher Iley
13. Birthplace: Md.

MOTHER
14. Maiden name: Annie Carlisle
15. Birthplace: Md.

16. Informant: Mrs. Sallie L. Wardell
Address: Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 18 1945 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace, Md.

18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.

19. 1-18 1945 (Date rec'd by registrar) A. L. Levis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15, 1945, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to Jan 15 1945
and that I last saw her alive on Jan 15 1945

	DURATION
Immediate cause of death: cerebral hemorrhage	years
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: Edward L. Simon M. D. or other
Address: Havre De Grace Date signed 1-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

00570 P

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:
County Harford Co
City or town Edgewood Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Edgewood Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clarence Lanham (Lanham)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife Rose M
6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) April 25 1884

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace Danville Ill.
(Town, county, and state)
10. Usual occupation Non-Employed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Mrs Rose M. Lanham
Address Edgewood Hgts - Harford Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 2 - 1945 (month) (day) (year)
Cemetery or crematory Moreland Park
Location

16. Funeral director L. J. Ruark
Address 5305 Harford Rd

19. 1/31/45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1945 at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	1 hr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard C. Palmer M.D.
Deputy Medical Examiner
for Harford County M. D. or other
Address Bel Air, Md. Date signed 1/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2901 Lake Merritt

Fru 6071 [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

00571

CERTIFICATE OF DEATH

Reg. Diat. No. 183

1. PLACE OF DEATH:
County Harford
City or town White Hall R F D
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town White Hall R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME George Holmes Lemmon

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Laura S Lemmon
6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 29 1883

8. AGE:

Years	Months	Days	If less than one day
63	3	2	hrs. min.

9. Birthplace Harford Co Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name George Lemmon
13. Birthplace Harford Co. Md.
MOTHER 14. Maiden name Mary Jane King
15. Birthplace Harford Co
16. Informant Mrs. C H. Lemmon
Address Rocks Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan 4 1945 (month) (day) (year)
Cemetery or crematory Bethel
Location White Hall R F D Md
18. Funeral director Howard S. Mackenzie
Address White Hall. Md
19. Jan 4 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1945, at 2 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 1943 to Jan. 1 1945
and that I last saw him alive on Jan. 1 1945
Immediate cause of death Coronary Thrombosis

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. M. France M. D. or other
Address Parkton, Md Date signed 1/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 8 1945
BUREAU U.S.

Evidence for change of age of deceased is shown on FILM No G92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99-2)

CERTIFICATE OF DEATH

00572

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2-3 yrs.
Hospital, institution, or street address where death occurred: home Ontario St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Alleghany
City or town: Covington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 119 S. Marion St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie Essie Leviseay

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Charles Andrew Leviseay
~~Dec. 26~~ 6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) ~~Sept 9~~ Dec. 26 - 1878

8. AGE:

Years	Months	Days	If less than one day
66 ~~67~~		14	hrs. min.

9. Birthplace: Lynchburg Va.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: Floyd Rodgers
13. Birthplace: Virginia

MOTHER
14. Maiden name: Alice Myers
15. Birthplace: Virginia

16. Informant: Mrs. William E. Fletcher
Address: Ontario St. Ext. Havre de Grace Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 10 1945 (month) (day) (year)
Cemetery or crematory: Covington
Location: Covington Va
18. Funeral director: Henry Tarring Sons
Address: Aberdeen Md

19. 1-10- 1945 (Date rec'd by registrar) A. L. Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9 1945, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1944, to January 9 1945
and that I last saw h.. alive on January 8 1945

Immediate cause of death	DURATION
Congestive heart failure	24 hrs
Due to: Auricular fibrillation	
Due to:	
Other conditions: hypertension arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Edward J. Simon M.D. M. D. or other
Address: Havre de Grace Date signed 1-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 25 1945
BUREAU V S.

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (R&P)

00573

CERTIFICATE OF DEATH

Reg. Diat. No. 184

1. PLACE OF DEATH:

County: Garland

City or town: Stut

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Garland

City or town: Stutz R.D. 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Kate E. Martin

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife: Edwin E. Martin

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 28 1862

8. AGE: Years	Months	Days	If less than one day
82	11	8	hrs. min.

9. Birthplace: Garland Co Ark (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housekeeping

FATHER 12. Name: David Boyle

FATHER 13. Birthplace: Garland Co Ark

MOTHER 14. Maiden name: Julia Rutledge

MOTHER 15. Birthplace: Garland Co Ark

16. Informant: Jno E. Martin

Address: Stuttgart Ark

17. Burial, cremation, or removal. Which?: Burial Date thereof: Jan 8 1945 (month) (day) (year)

Cemetery or crematory: Centre

Location: Four Hills Ark

18. Funeral director: W Howard Webb

Address: Fair View Rd

19. Jan 6 1945 (Date rec'd by registrar) Carl E. Trump Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1945 at 6:30 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Jan 7 1945

and that I last saw h alive on Jan 5 1945

Immediate cause of death: Cerebral Thrombosis — DURATION

Due to: Nephritis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Benjamin Dorris M. D. or other

Address: Lindsay Ark. Date signed 1-6-44

RE[illegible]
MAR 6 1945
BUREAU V.S.

Evidence for change of cause of death is shown on FILM No. G 94 APR 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

00574

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Kalmia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Alice Duvall Mitchell

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Henry F Mitchell
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 19-1849

8. AGE:

Years	Months	Days	If less than one day
95			hrs. min.

9. Birthplace: St Mary's Co., Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Robert F Duvall
13. Birthplace: Md
MOTHER 14. Maiden name: Juliana Frame
15. Birthplace: Md
16. Informant: Richmond Mitchell
Address: Bel Air, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 9/45 (month) (day) (year)
Cemetery or crematory: Rock Spring
Location: Near Forest Hill, Md
18. Funeral director: Deaver & Foley
Address: Bel Air Md
19. 1/9 (Date rec'd by registrar) 1944 Priscilla Fourrod Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 7 1945, at 11 20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1945, to Jan 7 1945, and that I last saw her alive on Jan 7 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia	3 da
Due to: Fracture of Hip	7 da
Due to: Accidental fall. cause	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: January 24, 1945
Where did injury occur? Place of residence (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): At home
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: Willard R. Hudson M. D. or other
Address: Forest Hill, Md Date signed: 1/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 8 1945
BUREAU V.S.

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

00575

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: 710 Market St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 710 Market St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Harry O'Neil Moore

3. (b) Social Security Number

4. Sex	5. Color or race	7.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Evaleen Moore — 8.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Feb 10, 1864

8. AGE:

Years	Months	Days	If less than one day
80	11	18	hrs. — min. —

9. Birthplace: Havre de Grace (Town, county, and state)
10. Usual occupation: Fisherman
11. Industry or business: Gunning & Fishing

FATHER
12. Name: Wm J Moore
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary O'Neil
15. Birthplace: Md.

16. Informant: Mrs Evaleen Moore
Address: 710 Market St. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30 1945 (month) (day) (year)
Cemetery or crematory: Angel Hill Cem
Location: Havre de Grace

16. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.

19. Jan. 29 1945 (Date rec'd by registrar) — G. K. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28 1945, at 5 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1944, to Jan 27 1945
and that I last saw h[illegible] alive on Jan 27 1945

Immediate cause of death	DURATION
Uremia	
Chronic Nephritis	
Due to Hypertension - Cardiac	
Due to Cerebral Accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: G. K. Lewis, M.D.
M. D. or other
Address: Havre de Grace Md. Date signed 1-29-45

RECEIVED
FEB 5 1905
BUREAU U.S.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

00576

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace No.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 711 Ontario St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph Henry Moore

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Bum Moore
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30 - 1872

8. AGE: Years	Months	Days	If less than one day
72	6	21	..... hrs. ..... min.

9. Birthplace Havre de Grace (Town, county, and state)
10. Usual occupation Business Manager
11. Industry or business
FATHER 12. Name Michael Moore
13. Birthplace Maryland
MOTHER 14. Maiden name Martha Moore
15. Birthplace Maryland
16. Informant Mrs. Mary Bum Moore
Address 711 Ontario St. Havre de Grace
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-28-45 (month) (day) (year)
Cemetery or crematory Mt. Erin
Location Havre de Grace
18. Funeral director Pennington & Son
Address Havre de Grace, Md.
19. 1-23-45 19..... (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1945, at 10:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943, to Jan 21 1945
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Edema of Lungs	
Degenerative Chronic Myocardosis	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D. M. D. or other
Address Havre de Grace Date signed 1/23/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

00577

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Bel Air Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bryarly Munnikhuysen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Novilla P Kirby ✓
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 18 - 1888

8. AGE:

Years	Months	Days	If less than one day
56	11	29	hrs. min.

9. Birthplace: Hartford Co Md
(Town, county, and state)

10. Usual occupation: Insurance

11. Industry or business

FATHER
12. Name: Wm J Munnikhuysen
13. Birthplace: Md

MOTHER
14. Maiden name: Ella Gover
15. Birthplace: Md

16. Informant: Mrs Novilla P Munnikhuysen
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 19/45 (month) (day) (year)
Cemetery or crematory: St Mary's
Location: Emmorton Md
18. Funeral director: Dean & Forwood
Address: Bel Air, Md

19. 1/18 1945 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17 1945 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 15 1944 to Jan 17 1945
and that I last saw h. l. M. alive on Jan 17 1945

Immediate cause of death	DURATION
Hypertensive CV disease	15 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gerald C. Palmer M D
Address: Bel Air Md. M. D. or other
Date signed 1/17/45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00578

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Amelia Norris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Alexander Norris
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 29 1855

8. AGE: Years 89 | Months 3 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace: Edgewood, Harford Co. Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Frederick Jacob Lautz
13. Birthplace: Germany

MOTHER
14. Maiden name: Frederica Emmrod
15. Birthplace: Germany

16. Informant: Leigh Norris
Address: Edgewood Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 3 1945 (month) (day) (year)
Cemetery or crematory: Trinity Lutheran
Location: Joppa, Harford Co. Md

18. Funeral director: Howard K. McComas & Son
Address: Aberdeen Maryland

19. Jan 3 1945 (Date rec'd by registrar) Marie M. Mundale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 1945 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1944 to Jan 1945 and that I last saw her alive on Dec 31 1944

Immediate cause of death	DURATION
Hypostatic pneumonia	4 wks
Chronic fibrous conjestion	
Due to Arterio sclerotic C.V. Disease	18 yrs
Due to	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Ralph Horsey M.D. M. D. or other
Address: Edgewood Md Date signed Jan 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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FEB 5 1945
BUREAU V.S.

08

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

00579

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH

County Harford

City or town Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:
St. Francis Villa

How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Market & Commerce
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Sister Mary Nemesia (Emma Gumbs)

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 2 - 1876

8. AGE: Years	Months	Days	If less than one day
69	—	6	..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business —

FATHER
12. Name Carl Gumsbey
13. Birthplace Germany

MOTHER
14. Maiden name Wilhelmina Wüst
15. Birthplace Germany

16. Informant St. Francis Villa Hosp. Records
Address Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/11/45 (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. 1-10- 1945 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1945 at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Jan 9 1945
and that I last saw h[illegible] alive on Jan 9 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Cerebral	
Due to Pneumonia	
Due to	
Other conditions Tb Kidneys	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles J. Foley M.D.

Address [illegible] Havre de Grace Md. Date signed Jan 10 45

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FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

00580

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Havre de Grace Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No
2.(a) If veteran, name war

3.(a) FULL NAME Arthur K Parker

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 8, 1878

8. AGE: Years: 66 | Months: 10 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: ~~Farmer~~ Brooklyn, N.Y.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Joseph K. Parker
13. Birthplace: Cecil Co., Md.

MOTHER
14. Maiden name: Martha Arthur
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Jean P. Wakefield
Address: Havre de Grace, Md. RD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 7, 1945 (month) (day) (year)
Cemetery or ~~cemetery~~: Parker Cem
Location: Harford Co., Md.

18. Funeral director: H. S. Bailey
Address: Darlington, Md.

19. Jan 6 1945 Bertha B. Knight
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 4 1945 at 12 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Died suddenly 19..... to 19.....
and that I last saw h..... alive on 19.....

Immediate cause of death	DURATION
Found dead in field	
Due to: Angina Pectoris	4 Weeks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. E. Gallion M. D. or other
Address: Darlington Date signed 1-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MAR 3 1945
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WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

00581

CERTIFICATE OF DEATH

Reg. Dist. No. 185—

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 days.
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: (Rural) Street
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RFD #2.
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3.(a) FULL NAME: Grant S Paxton

3.(b) Social Security Number: 217-24-3624

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Augusta Paxton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May - 28 - 1878

8. AGE: Years	Months	Days	If less than one day
66	7	6	..... hrs. ..... min.

9. Birthplace: Emmitsburg Fredrick Co., Md.
(Town, county, and state)
10. Usual occupation: Carpenter.
11. Industry or business

FATHER
12. Name: Samuel C. Paxton
13. Birthplace: Fredrick Co., Md.

MOTHER
14. Maiden name: Emily J. Null
15. Birthplace: Fredrick Co. Md.

16. Informant: Mrs Augusta Paxton
Address: Street, Md RFD #2.

17. Burial (Burial, cremation or removal. Which?) Date thereof Jan. 6, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Baltimore City
16. Funeral director: H. S. Baileys
Address: Darlington, Md.

19 Jan. 3 19 45 — C. L. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 19 45, at 2 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 19 44, to Jan 3 19 45
and that I last saw him alive on Jan 3 19 45

Immediate cause of death	DURATION
Cardio respiratory Failure	
Due to: Pulmonary Embolus	3 min.
Due to: Adenocarcinoma of Prostate	1 year.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Adenocarcinoma of Prostate, anaplastic type. Date of op. 12-13-44

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles N. Ingon M.D.
Address: Harford Memorial Hosp. Havre de Grace, Md. M. D. or other
Date signed: 1-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

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FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00582

CERTIFICATE OF DEATH

Reg. Dist. No. 18d

1. PLACE OF DEATH:
County Edgewood Harford
City or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 A Hartman St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alvina R. Phillips

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1944

8. AGE:

Years	Months	Days	If less than one day
	3	7	..... hrs. ..... min.

9. Birthplace Sharon Pa
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Alvin S. Phillips
13. Birthplace Sharon Pa

MOTHER
14. Maiden name Ruth Culp
15. Birthplace Sharon Pa

16. Informant Ruth C. Phillips
Address Edgewood Md, 11A Hartman St

17. Transportation (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (month) (day) (year)
Cemetery or crematory Cyril Reinlet
Location Farrell Pa

18. Funeral director Howard K. McConnaughey
Address Aberdeen Maryland

19. Jan. 15 1945 Marie M Mondale
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1945, at 9:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19..... to ..... 19.....
and that I last saw h..... alive on — 19.....

Immediate cause of death atelectasis right lung — DURATION 4 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Jan 6 1945
Where did injury occur? Home
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury Jumped three Pennies Injured at work? —

23. SIGNATURE Gerald C. Palmer M.D.
Deputy Medical Examiner
Harford County
M. D. or other
Address Bel Air, Md. Date signed 1/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-7)

CERTIFICATE OF DEATH

00583

Reg. Diat. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
FOUNTAIN GREEN HOSPITAL
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural - Magnolia
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Magnolia
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LORETTA M. PIEKENBROCK

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Married

6.(b) Name of husband or wife: Karl Piekenbrock
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 24, 1912

8. AGE: Years	Months	Days	If less than one day
32	8	11	..... hrs. ..... min.

9. Birthplace: Harford co. Md (Town, county, and state)
10. Usual occupation: Housf.
11. Industry or business

FATHER
12. Name: Thomas A. Monks
13. Birthplace: Md

MOTHER
14. Maiden name: Mary Phelps
15. Birthplace: Md

16. Informant: Hospital Record.
Address: Rock Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 8/45 (month) (day) (year)
Cemetery or crematory: Rock Spring
Location: Near Forest Hill

18. Funeral director: Dean & Todd
Address: Bel Air Md

19. 1/6 (Date rec'd by registrar) 1945 Priscilla Fawood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 5 1945, at 4:23 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 1944, to Jan 5 1945
and that I last saw her alive on Jan 4 1945

Immediate cause of death: Rheumatic Heart Disease — DURATION: 6 Mos
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M.D
M. D. or other
Address: Forest Hill, Md Date signed: 1/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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FEB 8 1945
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50) X

CERTIFICATE OF DEATH

00584

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Gibson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Gibson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Sarah E Ray

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	W

6.(b) Name of husband or wife: Edwin Ray
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feby 5 – 1859

8. AGE: Years: 85 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Mon

11. Industry or business

FATHER
12. Name: Henry Williamson
13. Birthplace: Md

MOTHER
14. Maiden name: Lucy Tasker
15. Birthplace: Md

16. Informant: Mrs Estella Hemsley
Address: Bel Air

17. Burial (Burial, cremation, or removal. Which?) Date thereof: January 20/45 (month) (day) (year)
Cemetery or crematory: Clark's Chapel
Location: Gibson

18. Funeral director: Dean & Foster
Address: Bel Air Md

19. 1/18 19 4 (Date rec'd by registrar) Priscilla Sawood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 19 45 at 1055 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 19 44 to Jan 16 19 45
and that I last saw h. alive on Jan 13 19 45

Immediate cause of death	DURATION
Carcinoma R breast	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gerald C. Palmer M.D.
M. D. or other
Address: Bel Air, Md. Date signed 1/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 8 1915
BUREAU V.S.

C-9 1631

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

CB 00585

Reg. Diat. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen Proving Ground Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 YEARS

Hospital, institution, or street address where death occurred:
STATION HOSPITAL, A.P.G. Md

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ~~Md~~ Ill County: Cook

City or town: Chicago
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4955 Prairie Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME
LEROY RICHARDSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	married/divorced

6.(b) Name of ~~husband~~ or wife: Ruth Morris Rich

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 27 Nov 1914

8. AGE:

Years	Months	Days	If less than one day
30	1	28	hrs. min.

9. Birthplace: Gilmore ARKANSAS
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Road Work

FATHER
12. Name: —
13. Birthplace: —

MOTHER
14. Maiden name: Mary Richardson
15. Birthplace: —

16. Informant: The Surgeon
Address: Station Hospital, A.P.G., Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan 27 1945 (month) (day) (year)

Cemetery or crematory: Marked Tree

Location: Arkansas.

18. Funeral director: Elmer E. Bullock

Address: 536 Lewis St. Havre de Grace, Md

19. Jan. 27 1945 (Date rec'd by registrar) Nellie Z. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 Jan 1945 at 2400 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h/ alive on 25 Jan 1945

Immediate cause of death	DURATION
Acute endocarditis	7 weeks
Due to: Syphilis of cerebral arteries	
Due to: —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. D. Hoffman 1st Lt MC
M. D. or other

Address: Chief of Coll. Service Date signed 25 Jan 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 3 1945
BUREAU V.I.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79)

00586

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 days.
Hospital, institution, or street address where death occurred: Harford Memorial Hosp.
How long in hospital or institution? 42 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Rural (Havre de Grace)
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frances Katherine Ritchie

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Merhl Ritchie
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 8, 1897
8. AGE: Years: 47 Months: 9 Days: 13 If less than one day: hrs. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Own home.
FATHER 12. Name: Granville Left Witch
13. Birthplace: Virginia
MOTHER 14. Maiden name: Margaret Bragg
15. Birthplace: Virginia
16. Informant: Merhl Ritchie
Address: Havre de Grace, Rt 3, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/24/45 (month) (day) (year)
Cemetery or crematory: Angelus Chapel
Location: near Churchville, Md.
18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.
19. 1-23- 45 (Date rec'd by registrar) O. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21 19 45 at 4 10/A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 10 19 44, to Jan 21 19 45
and that I last saw her alive on Jan 21 19 45.

	DURATION
Immediate cause of death: Inanition	2 mo.
Due to: Pernicious Anemia	
Due to:	
Other conditions: Pyelitis, Cystitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Liver degeneration, Pyelitis, Cystitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles V. Logan M.D. M. D. or other
Address: Havre de Grace, Md. Date signed 1-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00587

Reg. Diat. No. 184

1. PLACE OF DEATH:

County: Harford

City or town: Street R.D. 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos.

Hospital, institution, or street address where death occurred: Dublin-Ady Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Street R.D. 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Dublin-Ady Rd. Near Maryland

(If rural, give LOCATION) Farm Col.

2.(a) If veteran, name war:

3. (a) FULL NAME Paul Eugene Rockey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife: None

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 23 1944

8. AGE: Years	Months	Days	If less than one day
	1	5	hrs. min.

9. Birthplace: Street R.D. 2 Harford Co. Md.

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Eugene Foard Rockey

13. Birthplace: Philadelphia Penn.

MOTHER

14. Maiden name: Alice Virginia Matson

15. Birthplace: Darlington, Md.

16. Informant: Eugene Foard Rockey

Address: Street, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 30 1945 (month) (day) (year)

Cemetery or crematory: Dublin Cem

Location: Harford Co., Md.

18. Funeral director: H. S. Bailey

Address: Darlington Md.

19. Jan. 29, 1945 (Date rec'd by registrar) M. H. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1945 at 9:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Congenital Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Josiah A. Hunt. M.D.

Asst. Deputy Medical Examiner

Address: Cardiff, Harford Co. Md. Date signed: 1/28/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 6 1945
BUREAU V.E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

00588

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Harford

City or town: Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Rural - Cardiff

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mill-Green

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary E Rutledge

3. (b) Social Security Number:

4. Sex: Female | 5. Color or race: White | 6. (a) ~~Single, married, widowed, or divorced~~: Widow

6.(b) Name of husband or wife: Nicholas Rutledge

Dead

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1869

8. AGE: Years: 76 | Months: 0 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Harford Co. Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home

FATHER 12. Name: Andrew Farmer

13. Birthplace: Harford Co., Md.

MOTHER 14. Maiden name: Mary A Carr

15. Birthplace: Harford Co., Md.

16. Informant: Mrs. Mary A. Dayer

Address: Street, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 20 1945 (month) (day) (year)

Cemetery ~~or crematory~~: Highland Cem.

Location: Harford Co., Md.

18. Funeral director: H. S. Bailey

Address: Darlington, Md.

19. 1/19 19 45 Priscilla Fawwood

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 19 45 at 10 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31 19 43 to Jan 18 19 45 and that I last saw her alive on Jan 16 19 45

	DURATION
Immediate cause of death: Cerebral Thrombosis	2 da.
Due to:	
Due to:	
Other conditions: Chr Myocardial Disease, Gen. Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill, Md. Date signed 1/19/45

RECEIVED
FEB 8 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

00589

CERTIFICATE OF DEATH

Reg. Diat. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Perryman

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Perryman

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Eloise Elizabeth Dennison

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 8. 1944

8. AGE:

Years	Months	Days	If less than one day
	3		..... hrs. ..... min.

9. Birthplace: Perryman (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Charles Dennison

13. Birthplace: Perryman Md.

MOTHER

14. Maiden name: Hazel Kenley

15. Birthplace: Perryman Md

16. Informant: Miss Hazel Kenley

Address: Perryman Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 9 1945 (month) (day) (year)

Cemetery or crematory: Union M. E.

Location: Near Aberdeen Md

18. Funeral director: Henry Fanning Sons

Address: Aberdeen Md.

19. Jan. 9 1945 (Date rec'd by registrar) Nellie R. Riley (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 1945, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Bronchopneumonia	2 da
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work?

23. SIGNATURE: Gerald E. Palmer M.D. Deputy Medical Examiner Harford County M. D. or other

Address: Bel Air, Md. Date signed 1/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 3 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00590

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford

City or town Aberdeen

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

141 Post Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Aberdeen Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 141 Post Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Franklin Whitaker Standiford

3. (b) Social Security Number 212-05-0702

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife N. Blanch Standiford

6(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Sept. 6 - 1877

8. AGE: Years 67 | Months 4 | Days | If less than one day hrs. min.

9. Birthplace Harford Co. Md (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Telephone Foreman

FATHER 12. Name J. Walter Standiford

13. Birthplace Clayton Harford Co

MOTHER 14. Maiden name Laura Bramble

15. Birthplace Harford Co Md

16. Informant Mrs. N. Blanch Standiford

Address 141 Post Road Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19 1945 (month) (day) (year)

Cemetery or crematory Union Chapel

Location Wilna Harford Co. Md

18. Funeral director Henry Fanning & Sons

Address Aberdeen Md.

19. Date rec'd by registrar Jan. 18 1945 Registrar Nellie H. Riley

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1945 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17 1945 to January 17 1945 and that I last saw h~~im~~ alive on January 17 1945

Immediate cause of death	Coronary Thrombosis	DURATION 1 Day
Due to	Arterio Sclerosis	10 years
Due to	Chronic Myocarditis	10 years
or		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Carlock MD M. D. or other

Address Havre de Grace Date signed Jan 17 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 3 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-Q)

CERTIFICATE OF DEATH

1945

Reg. Dist. No. 74 182

1. PLACE OF DEATH:
County Baltimore
City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County Harford
City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war No -

3. (a) FULL NAME Frank A. Sterbak

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marie L.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1874

8. AGE: Years 70 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business ✓

FATHER
12. Name Frank Sterbak
13. Birthplace

MOTHER
14. Maiden name ✓
15. Birthplace

16. Informant Mr. Frank Sterbak
Address Fallston Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 22 45 (month) (day) (year)
Cemetery or crematory Priend's
Location Fallston
18. Funeral director Hopkins & Goss
Address Benson, Md.

19. 1/19 1945 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1945 at 8 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 45 to Jan 18 44 1945
and that I last saw h alive on ..... 19.....
Immediate cause of death Acute myocardial failure — DURATION
Due to Cardio Renal disease.
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)
Major findings of operations.....
Date of op. .....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C M Hopkins M. D. or other
Address Bel Air Md. Date signed 1/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 8 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

00592

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Bluerock Neck
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: HARFURD
City or town: FOREST HILL, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Minnie J. SWAM

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: James H. Swam
6.(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): Feb 28 1883

8. AGE: Years	Months	Days	If less than one day
61	10		hrs. min.

9. Birthplace: Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Wm. T. Waeters
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary A. Harmeson
15. Birthplace: Pa

16. Informant: Mr. James H. Swam
Address: Forest Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25 1945 (month) (day) (year)
Cemetery or crematory: Cemetery (Center)
Location: Forest Hill Md

18. Funeral director: Hamberger & Grass
Address: Benson Md

19. 1/25/ 1945 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 22 1945, at 7:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 1ST 1945, to JAN. 22 1945 and that I last saw h.&m. alive on JAN. 21ST 1945

Immediate cause of death	DURATION
CEREBRAL THROMBOSIS	45 min.
DIABETES MELLITUS	5 yr.
Due to	
Due to	
Other conditions CHR MYOCARDIAL DISEASE	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Willard P. Hudson
M. D. or other
Address: Forest Hill, Md Date signed 1/22/45

RECEIVED
FEB 8 1945
BUREAU U. S.

WITHIN CORPORATE LIMITS ☐

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-C)

CERTIFICATE OF DEATH

00593

Reg. Diat. No. 125

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mo.
Hospital, institution, or street address where death occurred: Harford Memorial Hosp
How long in hospital or institution? 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 133 Beaver St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Thomas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-9-1935

8. AGE:

Years	Months	Days	If less than one day
9	1	4	..... hrs. ..... min.

9. Birthplace Ohio (Town, county, and state)
10. Usual occupation Student
11. Industry or business

FATHER
12. Name Llewellyn Thomas
13. Birthplace England.

MOTHER
14. Maiden name Naomi Freek.
15. Birthplace Ohio.

16. Informant Mother Mrs Llewellyn Thomas
Address 133 Beaver St. Havre de Grace.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/45 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace
18. Funeral director Pennington & Son
Address Havre de Grace, Md.

19. 1-14 1945 (Date rec'd by registrar) O. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 19 45, at 10 19 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to Jan 13 19 45 and that I last saw h.. alive on Jan 13 19 45

	DURATION
Immediate cause of death Cardio-Respiratory failure	41 hrs
Due to Edema of glottis, due to hemolytic strepto.	
Due to Toxic Myocarditis & coccus	2 days
Due to Edema of Larynx Cong.	3 days
Due to	
Other conditions Streptococcic sore throat.	

(Include pregnancy within 3 months of death)

Major findings of operations Tracheotomy Date of op. 1-13-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Charles T. Legon M.D. M. D. or other
Address Harford Memorial Hosp Havre de Grace, Md. Date signed 1-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

00594

CERTIFICATE OF DEATH

Reg. Diat. No. 182

1. PLACE OF DEATH:
County HARFORD
City or town RURAL - Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Birth
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Rural - Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No. Kalmia
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME RANSOM BRIAN WYATT

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WH.	Infant

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1944

8. AGE: Years	Months	Days	If less than one day
	5	13	hrs. min.

9. Birthplace Kalmia, Harford Co, Md (Town, county, and state)
10. Usual occupation Infant
11. Industry or business
FATHER 12. Name Ransom Wyatt
13. Birthplace Wilkes Co, N.C.
MOTHER 14. Maiden name Azalee Bare
15. Birthplace Ashe Co, N.C.
16. Informant Azalee Wyatt
Address Bel Air, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20/45 (month) (day) (year)
Cemetery or crematory Ebenezer
Location Ashe Co N.C.
18. Funeral director Ransom Wyatt. Father
Address Bel Air. Route 1.
19. 1/18 1945 Priscilla Sowood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945, at 3:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1945 to Jan 17 1945 and that I last saw h— alive on — 19—

Immediate cause of death	DURATION
Congenital Heart Disease	Since Birth
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard R Hudson M. D. or other
Address Forest Hill, Md Date signed 1/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 8 1945
BUREAU V.S.